



## Child Fatality Report Release of Information to the Public

---

**Person ID:** 95778111

**County of Child's Residence:** HARRIS

**Gender:** Female

**Age:** 0 Year(s) 2 Month(s)

**Date of Death:** 07/18/2018

On the date of the fatality, the child was not in DFPS conservatorship and was living with the child's parent, a managing conservator, a legal guardian or other person entitled to the child's possession.

---

**Child's Name:** Robin,Jazmine R

**Current Report(s) of Abuse/Neglect:**

**Intake Date(s):** 07/14/2018

**Summary of Allegation(s)/Investigation:**

The department received a report that the deceased child was brought to the hospital by the child's mother and the mother's paramour with bruising all over, and was very pale and not breathing. It was reported that the deceased child had bite marks on her hands. When the deceased child's mother was asked about the bruising, the mother said the bruises had been there from the time the child was released from the NICU little more than a week earlier and a CPR incident a week earlier. The deceased child's mother stated that the bite marks on the deceased child's hands were from the child's two year old sibling. The bruises were in multiple stages of healing.

**Investigation Findings:**

Upon investigation, the deceased child's mother and father stated the child stopped breathing a week earlier, and they had to perform CPR to revive her. The parents stated they performed CPR for 45 minutes and were able to revive the child. The parents stated they did not call 911, or seek medical care for the child at that time because they didn't want the hospital to call CPS. The deceased child received no medical care after this incident.

The mother stated that earlier in the morning of this second incident, the father woke her up reporting that something was not right with the deceased child when he got up to feed her. It was reported that the child had a bruise on her hand and was very pale at this time. The father was able to eventually get the deceased child to eat a little bit. The deceased child's mother left for work. The father called the mother later in the day asking her to come home because the deceased child was not acting right. The child's tongue was stuck to the top of her mouth and neither parent could get the child to eat. About an hour later, the mother bathed the child and dressed her. At this time the mother noticed that the child's eyes rolled to the side. The parents then made the decision to take the child to the hospital where they arrived about an hour after the bath. The mother reported that the child became unresponsive in the car when the parents arrived in the parking lot of the hospital.

While in the hospital, the deceased child's injuries were concluded as being a result of trauma and physical abuse. The deceased child, her two year old sibling, and her parents lived with the maternal grandmother and five other adults. Several household members were interviewed and reported that the mother and father did not allow other people to be a caregiver for the child. The mother was drug tested and the results were negative; the father was drug tested and the results were positive for amphetamines and methamphetamines. The mother then blamed the deceased child's two year old sibling for biting the deceased child and said the bruises on the deceased child were from her six week stay in NICU and on the CPR conducted on her the week before. The maternal grandmother believed the child's bruises were from an undiagnosed illness and the child was not injured in any way. During interviews between CPS and the other adult family members, the parents left the hospital and did not return. The agency was granted emergency custody of the child's two year old sibling. The child was later pronounced deceased.

The autopsy showed that the deceased child had several bruises and abrasions on her body, a bite mark on the right arm, bilateral bruising on the head and eyes, hemorrhages in both eyes, possible fractures of the ribs, long bones, and scalp, and the brain showed damage. The cause and manner of death are pending further testing by the medical examiner.

Law enforcement did investigate, but charges were pending at the time of case closure.

The allegations of physical abuse of the deceased child by the deceased child's mother and father were confirmed. Both parents stated they were the only primary care givers for the deceased child, which was confirmed by other household members. Based on the medical reports of injury indicative of physical abuse, the autopsy report showing the child had multiple bruises of unknown origin, and the parents' lack of medical care for the child, there is reason to believe physical abuse was inflicted upon the deceased child by her parents which lead to the child's death. The allegations of medical neglect of the deceased child by the deceased child's mother and father were confirmed. Both parents stated the child stopped breathing a week prior to her death, and they had to perform CPR to bring her back. The parents stated they did not call 911, or seek medical care for the child at that time because they didn't want the hospital to call CPS. The allegations of neglectful supervision of the deceased child by the deceased child's mother and father were confirmed. Both parents admitted to historic drug use. The mother was drug tested via oral swab and the results were negative. The father was drug tested via oral swab and the results were positive for amphetamines and methamphetamines. The father drug-tested positive for amphetamines, methamphetamines, cocaine and marijuana and the mother drug-tested positive for marijuana on a court-ordered test. The hair follicle test, along with the parents' admittance to using drugs, indicates the parents have been under the influence of an illegal substance while providing care for the children. There is a reason to believe the parents were neglectful in their supervision of their children while under the influence.

Safety and Risk Assessment Factors Identified: 07/15/2018 SDM Safety Assessment-Initial: Unsafe; 07/15/2018 SDM Risk Assessment-Very High; 07/27/2018 SDM Safety Assessment-Initial-Unsafe

#### **Other Services:**

Counseling for family, individual, group, etc.; drug or alcohol abuse testing or treatment

**Other Actions Taken to Mitigate Risk:**

The agency was granted custody of the child's two year old sibling and he was placed in foster care.

**If one or more children were previously removed from the home, for each conservatorship episode, summarize dates of conservatorship and type of placement at the end of conservatorship:**

N/A

**Previous Report of Abuse/Neglect:**

**Intake Date(s):** 06/02/2008

**Summary of Previous Allegation(s)/Investigation:**

The agency received a report stating that the deceased child's father inappropriately touched [REDACTED]. The report stated that the child's father has a history of inappropriately touching family members.

**Investigation Findings:**

The investigator interviewed [REDACTED] and they denied sexual abuse by the deceased child's father. The deceased child's father denied trying to choke [REDACTED] or that the child's paternal grandmother found him on top of one of [REDACTED]. The deceased child's father admitted to pulling [REDACTED]'s pants down and touching her buttocks while she was sleeping when he was eleven years old. The deceased child's father reported that when he was in the second grade, he asked a little boy if he could touch his private area and the little boy said no. The deceased child's paternal grandparents both stated that the current report is a duplicate of another report that has already been addressed. Both paternal grandparents deny that the deceased child's father touched [REDACTED], but confirmed that he touched [REDACTED]'s buttocks two years earlier. The paternal grandparents agreed to the paternal grandmother sleeping in the room with [REDACTED] and the paternal grandfather sleeping in the room with the deceased child's father.

The allegations of sexual abuse of [REDACTED] by the child's father were not confirmed. [REDACTED] did not make an outcry of sexual abuse by the child's father. The deceased child's paternal grandparents denied that the deceased child's father touched [REDACTED].

**Safety and Risk Assessment Factors Identified:**

06/13/2008 Safety Assessment - Conditionally Safe / Safety Plan Completed

08/08/2008 Risk Assessment - Risk Indicated

Child Vulnerability - Somewhat

Caregiver Capability - Very Little

Quality of Care - Very Little

Maltreatment Pattern - Very Little

Home and Social Environment - Very Little

Response to Intervention - Very Little

Protective Capacities - Very Little

Case Action: FBSS

**Services and Referrals Provided to the Family:****Other Services:**

Counseling for family, individual, group, etc.; worker role-modeling

**Other Actions Taken to Mitigate Risk:**

A safety plan was put into place placing [REDACTED] in the bedroom with the child's paternal grandmother and the child's paternal grandfather in the room with the child's father to prevent future risk of abuse or neglect.

**Previous Report of Abuse/Neglect:**

**Intake Date(s):** 08/10/2010

**Summary of Previous Allegation(s)/Investigation:**

The agency received a report stating that the deceased child's paternal grandmother called law enforcement stating that [REDACTED] reported that the deceased child's father came into her bedroom and touched her on her leg around the knee. The report stated that the deceased child's grandmother also reported other incidents in other counties that had been reported to CPS. The report stated that law enforcement suggested to the deceased child's paternal grandmother that she place the deceased child's father out of the home and she reported that due to his history no one will have him in their house.

**Investigation Findings:**

[REDACTED] was interviewed and she admitted that the deceased child's father came into her room and put his hands under the covers and put it on her knee and began to slide it up her side. She stated she rolled over and saw him leaving. She denied he had done anything else to her. She stated that she told her uncle and her uncle told her parents and then her [REDACTED] called the police. She stated that the deceased child's father was placed in the Juvenile Detention Center the next day. The investigator interviewed [REDACTED] and she denied any abuse but reported she was aware of something happening to [REDACTED]. The deceased child's paternal grandmother admitted that the deceased child's father has a history of sexually acting out. She described two other occasions with other relatives. She reported that they have been trying to find alternative placements for him. The deceased child's paternal grandfather confirmed the grandmother's explanation. The deceased child's father's probation officer confirmed that he was in Juvenile Detention. The deceased child's father was interviewed and admitted to going into [REDACTED]'s room, placing his hand under her blanket and putting his hand on her knee. He stated he does not know why he went in his [REDACTED]'s room.

During a Juvenile Detention hearing, the deceased child's father was ordered into the agency's custody. The agency was granted custody of the deceased child's father and he was removed from the home.

The allegations of neglectful supervision of [REDACTED] by the deceased child's paternal grandparents were not confirmed. The deceased child's paternal grandparents acted appropriately by calling in a CPS report and reporting the deceased child's father to his probation officer when they were notified that he went into [REDACTED]'s room and put his hand on her knee. The deceased child's father was placed in the Juvenile Detention Center.

The allegations of sexual abuse of [REDACTED] by the deceased child's father were not confirmed. [REDACTED] admitted that the deceased child's father came into her room and put his hands under the covers and put it on her knee and began to slide it up her side. [REDACTED] denied being sexually abused by the deceased child's father.

The allegations of refusal to accept parental responsibility of the deceased child's father by the deceased child's paternal grandparents were confirmed because they would not allow the deceased child's father to return home and did not find alternative care for him. The deceased child's paternal grandparents acted appropriately by calling in a CPS report and reporting him to his probation officer when they were notified that he went into [REDACTED]'s room and put his hand on her knee. The deceased child's father was placed in the Juvenile Detention Center. They further notified the Judge that they had no other alternative placement to send Jason to and requested that the agency take custody of him. The agency was granted custody of the deceased child's father and he was placed outside the home.

**Safety and Risk Assessment Factors Identified:**

08/16/2010 Safety Assessment - Safe / No Safety Plan Needed

09/09/2010 Risk Assessment - Risk Indicated

Child Vulnerability - Considerable

Caregiver Capability - Somewhat

Maltreatment Pattern - Somewhat

Home and Social Environment - Somewhat

Protective Capacities - Somewhat

Case Action: Removal

**Services and Referrals Provided to the Family:**

**Other Services:**

PATH (Youth Transition), Salvation Army, Utility Assistance

**Other Actions Taken to Mitigate Risk:**

The agency was granted custody of the deceased child's father and he was removed from the home.

**Previous Report of Abuse/Neglect:**

**Intake Date(s):** 03/04/2018

**Summary of Previous Allegation(s)/Investigation:**

The agency received a report that law enforcement received an anonymous call stating that the deceased child's two year old sibling was seen with bruising on his stomach, legs, arms, and buttocks. It was reported that the deceased child's maternal aunt witnessed the child's father hitting and possibly kicking the sibling. The report stated that the deceased child's mother was witnessed pinching the two year old sibling under his shirt. The report stated that while the family's apartment number was unknown, law enforcement believed the family resided in an apartment that they had previously made contact with and there was a concern of marijuana smell in the apartment.

**Investigation Findings:**

The deceased child's sibling was not seen by law enforcement or CPS from March 2018 until the subsequent child fatality investigation was received in July 2018 because they had moved and could not be located. When the family was located, the deceased child's father denied the allegations of physical abuse of the sibling. The father reported that a police officer came to their apartment in February 2018 and took pictures of the sibling and told them everything was fine. The father stated that he tried to get in touch with the CPS investigator multiple times. The father stated they then moved in with friends out of town. The child's mother confirmed the father's explanation. The sibling did not have any bruising on him in July 2018; however, the agency is not able to determine if physical abuse occurred to the sibling as alleged in this earlier investigation.

The agency was granted custody of the deceased child's sibling during the fatality investigation. The sibling was placed in a foster home due to no viable family placement options. The Judge granted a NO CONTACT order for the parents of the sibling. The Judge also granted a NO MOVE order for the sibling.

The allegations of physical abuse of the deceased child's sibling by the deceased child's mother and father were not able to be determined. The deceased child's parents left their residence knowing there was an open CPS case regarding the child's sibling. Neither of the child's parents cooperated with the CPS Investigator, or advised the local CPS Investigator of their new address out of town. The initial CPS office was unable to complete an investigation with the family; therefore the allegations of physical abuse regarding the 23 month old sibling of the deceased child by his parents and an unknown perpetrator could not be determined.

**Safety and Risk Assessment Factors Identified:**

07/15/2018 SDM Safety Assessment: Initial - Unsafe

07/28/2018 SDM Safety Assessment: Case Closure - Safe

07/28/2018 SDM Risk Assessment: Very High

Case Action: Close

**Services and Referrals Provided to the Family:**

**Other Services:**

Counseling for family, individual, group, etc.; information on grief counseling provided to the parents following the deceased child's death.

**Other Actions Taken to Mitigate Risk:**

The agency was granted custody of the deceased child's sibling during the fatality investigation. The sibling was placed in a foster home due to no viable family placement options. The Judge granted a NO CONTACT order for the parents of the sibling. The Judge also granted a NO MOVE order for the sibling.

**Other Previous Report of Abuse/Neglect:**

**Intake Date(s):**

**Summary of Previous Allegation(s)/Investigation:**

**Investigation Findings:**

**Safety and Risk Assessment Factors Identified:**

**Case Action:**

**Services and Referrals Provided to the Family:**

**Other Services:**

**Other Actions Taken to Mitigate Risk:**

Note: This report was prepared on 07/08/2019 and does not include corrections or updates, if any, that may be subsequently made to DFPS data on or after the date this report was prepared.